Integrated Care for Kids (InCK) Model

Overview

The Center for Medicare and Medicaid Innovation (Innovation Center) announced the eight awardees for the **Integrated Care for Kids (InCK) Model. The InCK Model,** tested under the authority of section 1115A of the Social Security Act, is part of a multi-pronged strategy to combat the nation's opioid crisis. The **InCK Model** is a child-centered *local service delivery* and *state payment model* aimed at reducing expenditures and improving the quality of care for children covered by Medicaid and the Children's Health Insurance Program (CHIP) through prevention, early identification, and treatment of priority health concerns like behavioral health challenges and physical health needs. The model will offer states and local providers support to address these priorities through a framework of child-centered care integration across behavioral, physical, and other child providers.

Why develop a model for children?

Children and youth with multiple chronic conditions and behavioral health challenges, including use of opiates and other substances, drive significant morbidity, health care utilization, and premature death. One in three children in Medicaid and CHIP have behavioral health needs, yet only one-third of those in need receive care.[1] Furthermore, adolescent deaths from drug overdose are increasing, and opioids caused over half of drug-related overdoses among youth in 2015.[2]

The current child health care system has challenges in identifying and addressing risk factors for physical and behavioral health conditions because the earliest signs of a problem may present outside of clinical care—such as behavioral problems in schools or chaotic family situations known to child welfare and foster care programs. Although a variety of federal, state, and local services exist to support children's health, accessing and coordinating services can be challenging for families and providers because programs operate separately, may have different eligibility criteria and enrollment processes, and often do not share information.

[1] Department of Health and Human Services, 2016. 2015 Annual Report on the Quality of Care for Children in Medicaid and CHIP.
[2] Department of Health and Human Services, 2017. Office of Adolescent Health "Opioids and Adolescents". Retrieved from here.

What are the model's goals?

The goals of the InCK Model are to improve child health, reduce avoidable inpatient stays and out of home placement, and create sustainable alternative payment models (APMs)[3].

1. **Improving child health outcomes,** including preventing substance use disorder
2. **Reducing avoidable inpatient stays and out-of-home placements** including foster care
3. **Creating sustainable APMs** that ensure provider accountability for cost and quality outcomes

How will the model achieve these goals?

The InCK Model will support states and local providers to conduct early identification and treatment of children with health-related needs across settings. Participants will be required to integrate care coordination and case management across physical and behavioral health and other local service providers to provide child- and family-centered care. Finally, through the APM that is developed under this model, states and local providers will share accountability for cost and outcomes. These interventions are designed to increase behavioral health access, respond to the opioid epidemic and positively impact the health of the next generation.

Early identification and treatment	Integrated care coordination and case management	Development of state-specific APMs
• of children with multiple physical, behavioral, or other health-related needs and risk factors through population-level engagement in **assessment and risk stratification**.	• across **physical health, behavioral health, and other local service providers** for children with health needs impacting their functioning in their schools, communities, and homes.	• to align payment with care quality and support **accountability for improved child health outcomes** and long-term health system sustainability.

InCK Model funding will allow awardees the flexibility to design an intervention for their local communities that aligns health care delivery systems with child welfare supports, educational systems, housing and nutrition services, mobile crisis response services, maternal and child health systems, and other relevant service systems. Model participants will strengthen community capacity to provide more effective, efficient, and affordable care through improved provision of home- and community-based services (HCBS), reducing unnecessary inpatient stays, and out-of-home placements. State Medicaid agencies will work with CMS to develop APMs that are responsive to the local contexts and priorities. The APMs will leverage the broad array of existing mandatory and optional Medicaid and CHIP benefits to empower providers and promote cost-savings, improve quality, and state flexibility.

---

[3] Alternative payment models for the purposes of the InCK Model are not Alternative Payment Models as defined at 42 CFR §1305 for the purpose of the Quality Payment Program, which are defined as: (1) A model under section 1115A of the Act (other than a health care innovation award); (2) The Shared Savings Program under section 1899 of the Act; (3) A demonstration under section 1866C of the Act; (4) A demonstration required by Federal law.

Who will participate in the model?

The key participants in the InCK Model will be the state Medicaid agency, a local entity called a "Lead Organization," and a Partnership Council.

Lead Organizations are HIPAA-covered entities that will receive funding to convene community partners to integrate coordination and management of the InCK Model's core child services for the attributed population. The Lead Organization will be accountable for improving population-level care quality and outcomes and developing service integration protocols and processes.

State Medicaid Agencies will support local implementation by providing population-level data for the geographic service area, supporting the development of information sharing arrangements and infrastructure, working to align support for the model across child-focused state agencies, and developing the pediatric APM. State Medicaid agencies must commit to participating in the model either as a partner or as the Lead Organization.

Partnership Councils will include representation from the local health department, community stakeholder representatives, Medicaid payers, and all applicable organizations delivering Core Child Services. The Partnership Council, convened by the Lead Organization, has the primary responsibility of devising strategies and processes to achieve the coordination of service types for the model.

Whom will the model serve?

InCK Model awardees must serve all Medicaid-covered children from birth to age 21 residing in the designated service area, regardless of whether they are included in specialized Medicaid health plans, managed care organizations, or health homes. Awardees may also choose whether to include CHIP beneficiaries and Medicaid-covered pregnant women over the age of 21 in the attributed population.[4]

[4] For more information, please refer to "A 4.2.1.1.1. Model Service Area" on page 15 of the model's Notice of Funding Opportunity available here.

What are key design elements of the model?

Core Child Services

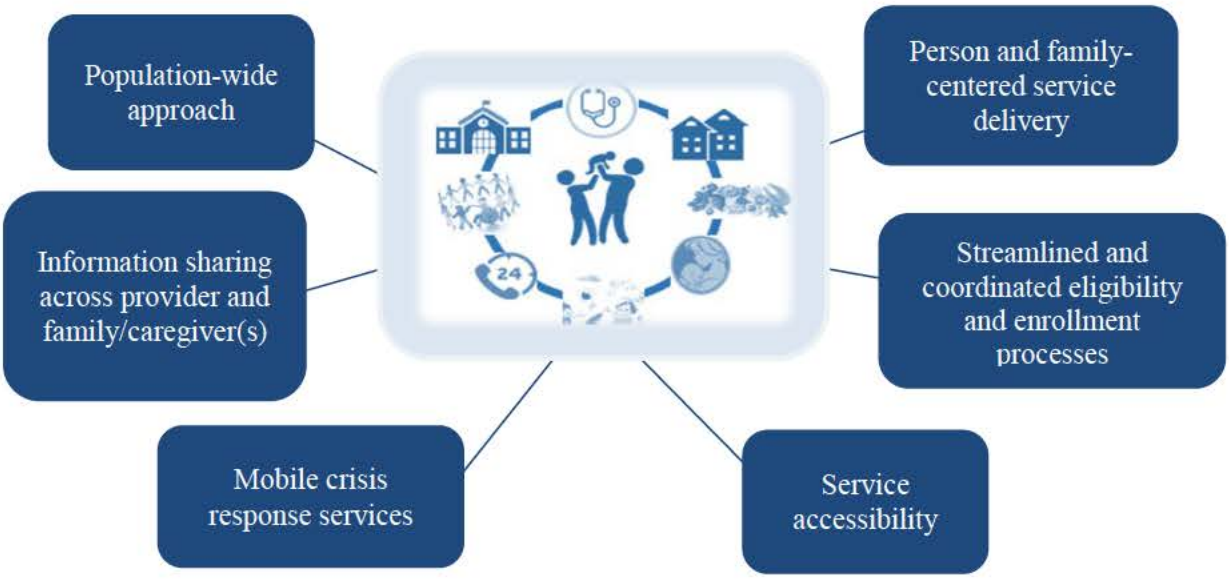
Lead Organizations will coordinate the integration of the following Core Child Service types, some of which may or may not be covered by Medicaid. Lead Organizations may consider including other child service types as appropriate.

- **Clinical care (physical and behavioral)**
- **Early care and education**
- **Title V Agencies**
- **Schools**
- **Housing**
- **Child welfare**
- **Food**
- **Mobile crisis response services**

Service Integration

Lead Organizations will coordinate the systematic integration of the Core Child Services within their model service area to provide integrated care coordination and case management. The service integration approaches will aim to provide children and caregivers with a single point of coordination for all providers and increase the provision of services at home and in the community. The InCK Model offers Lead Organizations and their partners the flexibility to employ service integration strategies most appropriate for achieving the model's aims in their local context.

The **six key service integration design characteristics** that awardees must incorporate into their implementation plan are:



Risk Stratification Approach and Tiered Service Delivery

The InCK Model service integration structure is based on population-wide risk stratification according to level of need. **Service Integration Levels (SILs)** consist of integrated care coordination and case management levels of increasing intensity appropriate for individual needs. The goal of stratification is to ensure that children receive the individualized, integrated care that they need in the least restrictive setting appropriate.

SIL 1 includes all children covered by Medicaid or CHIP up to age 21 residing in the awardee's geographic service area. Children in SILs 2 and 3 have multi-sector needs, functional impairments, and are at-risk for out-of-home placement or currently placed outside of their home.

Alternative Payment Models

States will work with CMS and the Lead Organization to design and implement one or more child-focused APMs in Medicaid (and CHIP, if applicable). States with existing APMs may meet the model's criteria by adapting an existing APM. The model will require participating states to develop APMs for supporting care coordination, case management, and mobile crisis response and stabilization services via existing authorities available under Medicaid and CHIP. The goals of the APMs are to 1) promote **accountability for improved outcomes**, such as rates of avoidable out-of-home placement and opiate use, and 2) ensure the model's **sustainability** long-term.

How was funding awarded?

InCK Model funding was awarded via eight cooperative agreements across seven states. CMS publicly released a competitive Notice of Funding Opportunity (NOFO) on February 8, 2019 with a June 10, 2019 application deadline. Each awardee can receive up to $16 million over the seven-year model. Funding may only be used to support model planning and implementation activities, not to deliver services to beneficiaries. Examples of allowable expenses for model funding include staff time for training, infrastructure costs for data sharing, service integration process planning, and preparation for implementation.

Which states and organizations are being awarded funding?

Almost $126 million in funding is being awarded to the states and organizations below.

State	Awardee Name	Type	Service Area
Connecticut	Clifford W. Beers Guidance Clinic	Lead Organization	Urban
Illinois	Ann & Robert Lurie Children's Hospital	Lead Organization	Urban
Illinois	Egyptian Health	Lead Organization	Rural
New Jersey	Hackensack Meridian Health Hospital	Lead Organization	Urban
New York	New York Department of Health	State Medicaid	Urban

State	Awardee Name	Type	Service Area
North Carolina	Duke University	Lead Organization	Urban
Ohio	Ohio Department of Medicaid	State Medicaid	Rural
Oregon	Oregon Health Authority	State Medicaid	Rural

What is the model timeline?

The InCK Model is expected to begin on January 1, 2020 with a **two-year pre-implementation period** in which CMS will work with states and Lead Organizations to assist the states in establishing or modifying any needed Medicaid and CHIP authorities and provide technical assistance to develop the infrastructure and procedures necessary for model implementation. A **five-year model implementation period** will follow, allowing states and Lead Organizations to implement their models and report required data to CMS.

Resources and Support

Email: HealthyChildrenandYouth@cms.hhs.gov
Visit: Integrated Care for Kids Model webpage